STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 27206 This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility from 11/3/09 through 11/10/09, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 144 residents. The sample size was 24 residents, which included 3 closed records, and 1 unsampled resident. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) NOTICE OF RIGHTS AND SERVICES The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Surveyor: 27206 Based on record review and interview, the facility	F 154		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 154	Continued From page 1	F 154		

failed to ensure that 2 of 24 residents or their legal representative were informed about the risks and benefits of psychopharmacological medications (Resident #8, #24).

Findings include:

Resident #8

Resident #8 was originally admitted to the facility on 4/16/09, with readmission on 9/18/09. The resident's diagnoses included quadriplegia, diabetes, hypertension, anxiety, and depression.

Medication orders included Ativan 1.0 mg every four hours as needed for anxiety, and Celexa 20 mg once a day for depression These two medications were listed on the Physician's Orders under the category Psychotropic Medications.

Review of the resident's medical record revealed a signed consent for Ativan, but no consent for Celexa. An interview with the nurse on duty, Employee #19, confirmed that Resident #8 did not sign a consent for Celexa.

Resident #24

Resident #24 was admitted to the facility on 9/30/09, with diagnoses including End Stage Renal Disease (with dialysis), cerebrovascular accident, hypertension, hypothyroidism, and dysphagia.

Medication orders included Ambien 5 mg as needed for insomnia, listed on the Physician's Orders under the category Psychotropic Medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 154	Continued From page 2 Review of the resident's medical record revealed no consent for Ambien, and the nurse on duty, Employee #20, confirmed that Resident #24 did not sign a consent for Ambien. The facility's undated "Use of Psychoactive Medications" policy, provided by the Director of Nursing (DON), Employee #11, included the following statement; "All patients will have a signed "consent to use psychotherapeutic medications" on their medical record, whenever the order is given to continue or begin this medication therapy. If the resident cannot sign, or their legal representative is not available, the physician writing the order will be notified and the medication cannot be given." The policy also listed the "psychotropic drugs to monitor," including antipsychotics, antianxiety agents, and sedatives/hypnotics. The list did not include antidepressants. The DON confirmed in an interview on 11/9/09 at 9:30 AM that antidepressants were not included in the Psychoactive Medications policy, but that hypnotics, such as Ambien, were included in the policy.	F 154		
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 27206 Based on document review and interviews, the facility failed to ensure prompt efforts were made to resolve grievances related to call light wait	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 3	F 166		

times.

Findings include:

Resident Council meeting minutes from the past three months were reviewed and revealed that a concern regarding long call light wait times was brought up by residents at the September meeting on 9/14/09. This concern was documented by a Social Worker, Employee #16, who was present at the meeting.

Employee #16 was interviewed on 11/10/09, at 9:00 AM on how she followed up on this grievance by the group of residents. The employee explained that she conducted a "Quality Circle" resident survey in September, whereby she asked 16 residents the following question: "Are you satisfied with the time it takes staff to respond to your call light?" Four residents indicated they were not satisfied, and the wait times stated by the residents in minutes were 10, 25, 30, and 40.

Employee #16 further described that she brought this information up at a Leadership Objectives meeting held on 10/23/09, in which both the Director of Nursing (DON) and the Administrator were present. Employee #16 was interviewed if the issue of call light wait times was addressed in any of the quarterly Quality Assessment and Assurance committee meetings, Employee #16 indicated it was not. The DON confirmed that this concern was not identified as an issue for committee action.

A group interview was conducted on 11/4/09 at 10:00 AM with 10 residents. One of the residents expressed his frustration in having to sometimes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 4 wait for one hour for assistance when using his call light. Another resident stated, "There's not enough staff to help." Employee #16 acknowledged that she did not inform the Resident Council that she was conducting a survey of call light wait times and did not report back to the group what efforts were being made by the facility to reduce the wait times.	F 166		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 27206 Based on interviews and document review, the facility failed to ensure staff responded to call lights in a timely manner, in a way to promote the dignity of residents. Findings include: Resident Council meeting minutes from the September meeting on 9/14/09 were reviewed and revealed that the Council members had a complaint about long call light wait times. This grievance was documented by one of the facility's social workers, Employee #16, who was present at the meeting. Employee #16 was interviewed on 11/10/09, at 9:00 AM on how the facility followed up on this grievance. The employee reported that she	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5 conducted a "Quality Circle" resident survey in September, whereby she asked 16 residents the following question: "Are you satisfied with the time it takes staff to respond to your call light?" Four residents indicated they were not satisfied, and the wait times stated by the residents in minutes were 10, 25, 30, and 40. On 11/4/09 at 10:00 AM, a group interview was conducted with 10 residents. One of the residents expressed his frustration at having to sometimes wait for one hour for assistance when using his call light. Another resident stated, "There's not enough staff to help." On 11/9/09, at 11:15 AM, Resident #25 approached this surveyor and wanted to express a grievance. The resident shared that she had a small urinary drainage bag attached to her leg, and that at night, if staff did not respond to her call light in a timely manner, the bag overflowed and made her feel "uncomfortable". The resident indicated that this happened twice, when staff did not respond for 20 minutes after she pressed her call light.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by:	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 6 Surveyor: 22116 Based on resident and staff interviews, facility policy review and record review, the facility failed to ensure residents had the right to interact with members of the community outside the facility, and to make choices about aspects of their life in the facility that were significant to the resident for 2 of 24 residents (Resident #16, #6). Findings include: An interview with a Social Worker (Employee #10) on 11/6/09, where she said the policy of the facility was that no resident with a PICC (percutaneous inserted central catheter) was allowed to go out on pass, because of possible risk of drug use. Review of the facility policy "Resident Passes," effected 10/1/2006, specified the purpose of this policy was: 1) to provide residents with a pass out of the facility in accordance with regulatory skilled nursing facility standards, residents clinical status and pay source. 2) residents with a medical history of substance abuse, who were receiving intravenous therapy via a PICC line were not eligible for the pass process. 3) residents shall be assessed first by the attending physician to be medically stable to go out on pass. 4) Residents will leave the building only with a responsible party. Review of the policy did not specify anyone with a PICC line could not go out on pass, only those residents who had a history of substance abuse.	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 7 Resident #16 Resident #16 was 36 years old and was admitted to the facility for an eight-week course of intravenous antibiotics. This was now his third week at the facility. An interview with Resident #16 on 11/6/09, revealed he had been denied pass privileges because he had a PICC line. His clinical record revealed no history of substance abuse. Resident #16 was concerned about his family and their safety, and they were currently residing in a family shelter. Resident #16 also indicated he was willing to take any kind of drug testing upon his return, but he was still denied to go on pass. Surveyor: 19948 Resident #6 Resident #6 was admitted to the facility on 10/20/09, with diagnoses that included aortocoronary bypass, atherosclerosis, hypertension and depression. Her admission was for a short term stay to recover from her heart surgery. The resident had an order written by the physician 10/21/09, for a pass as necessary. When the resident wanted to go out on pass, she was told that she could not go by herself because she had a history of having a heart attack. The order for the pass did not specify any special conditions for her to leave the facility. Resident #6 felt that her ability to go on pass was hampered by the availability of staff and the amount of time they were able to be out of the building.	F 242		
F 248	483.15(f)(1) ACTIVITIES	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248 SS=D	Continued From page 8 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 19948 Based on record review, staff interview and resident interview, the facility failed to provide a diversity of activities for 1 of 24 residents who was bedbound (Resident #1), and failed to provide activities as developed in the care plan for 1 of 24 residents (Resident #9). Findings include: Resident #1 Resident #1 was originally admitted to the facility on 5/5/09, with an re-admission date of 7/24/09. Her diagnoses included End Stage Renal Disease requiring dialysis treatment three times per week, diabetes (not controlled) and morbid obesity. She was presently in contact isolation for Clostridium difficile (C-diff.) Due to combination of factors including contact isolation, obesity and generalized weakness particularly of her extremities, Resident #1 was bedbound with confinement to her room except for her dialysis treatments. In the Minimum Data Set (MDS) completed on 8/6/09, and identified as a quarterly assessment, Resident #1 was documented as spending less	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 9	F 248		

than 1/3 of the time involved in activities. The previous MDS, the admission assessment completed on 5/18/09, documented the resident as spending 1/3 to 2/3 of her time engaged in activities. The only activities identified were watching TV and talking or conversing in her own room. An Activities Pursuit Patterns form completed on 7/24/09, identified Resident #1 as staying in bed all the time, spending time doing crossword puzzles, reading books and magazines, or watching television. The function of the Activities staff was identified as providing room visits to check supplies. Eleven active room visits were documented for the month of July, seven for the month of August and nine for the month of September. The only activities recorded were TV/radio in the room, an occasional reading/puzzle activity and some ice cream socials. Dialysis was counted as an activity.

Activities such as aromatherapy, arts and crafts, exercise, flower arranging, and grooming time were listed on the pre-printed Activities Record but there was no evidence that any of these activities were offered to Resident #1. In an Activities note, dated 11/3/09, it was documented that the resident mentioned the need of a tilted bedside table to facilitate her reading and doing crossword puzzles. The entry did not indicate if Activities was going to pursue the resident's request. In an interview with Employee #12 on 11/4/09, the employee indicated that she would be talking with maintenance about the tilt table. She confirmed that her room visits consisted of conversation and checking for supplies. The employee could not produce a policy concerning 1:1 room visits.

There was no evidence that specialized activities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 10	F 248		

were being developed or offered to Resident #1 that would enhance her daily routine. Adaptive equipment needed to be introduced that facilitated the resident's physical limitations such as holders for magazine or books. More specific 1:1 activities could have been offered or pursued (such as hand massage, nail care, talking books or aromatherapy).
Surveyor: 27206

Resident # 9

Resident #9 was originally admitted to the facility on 5/1/09, with readmission on 8/24/09. The resident's diagnoses included lung and prostate cancer, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and hypothyroidism. The minimum data set (MDS) dated 5/6/09, indicated the resident's cognitive skills for decision-making were not impaired.

During the survey period, Resident #9 was observed to be lying in bed for most of the day and eating meals in his room. When interviewed if he wanted to eat in the dining room, the resident explained that he preferred to eat in his room because of his hearing deficit.

A review of Resident #9's record revealed an Activities assessment conducted by the facility's Administrator, Employee #13. The assessment included the following sentence: "Will need room visits, as resident appears to tire easily."

Record review further revealed that an Activities care plan was developed by the Activity Assistant Lead, Employee #12, on 9/4/09. The following care plan approaches were listed:
1. Visit resident in room 1-2 times per week to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 11 discuss ongoing programs; 2. Discuss topics of interest; 3. Offer books and magazines; 4. Offer snacks or something to eat while eating; 5. Offer to turn on TV to resident's channel of choice; and 6. Document findings. A review of Activities notes revealed that the resident was visited once by Activity staff in September, and three times in October. On 11/6/09 at 8:00 AM, Employee #12 was interviewed. The employee explained that she developed the care plan for Resident #9, but the approaches were not being followed due to "staffing changes". The employee confirmed that the resident was visited by Activity staff only once in September and three times in October.	F 248		
F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 22116 Based on resident interviews, record review and staff interviews, the facility failed to ensure that medically-related social services were provided to attain or maintain the highest practicable physical, mental and psychosocial wellbeing for 4 of 24 residents (Resident #12, #15, #16, #9). Findings include:	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 12 Resident #12 Resident #12 was admitted to the facility 7/15/09, following an acute care hospitalization for cancer of the tongue. Resident #12 required a tracheostomy and gastrostomy tube. Resident #12 had several cycles of chemotherapy, however at this point was considered to be terminal and Hospice was recommended. Review of her clinical record revealed that the social service department had documented on 10/15/09, that one of the two hospice agencies contracted with the facility declined Resident #12, because there was no payer source. An interview and observation of Resident #12 on 11/5/09, revealed an anorexic individual, documented weight 91 pounds, but weekly weights have been discontinued because of resident's inability to tolerate activity of weighing. Resident #12 was very subdued in voice, difficulty expressing her needs. Resident #12 has an open wound on right side of neck that was approximately six by four inches, from trachea to behind right ear. This wound was a result of a neck abscess from the surgical wound. Resident #12 has lost all her hair as a result of the chemotherapy. A case conference record, attended by the Social Worker (Employee #17) assigned to Resident #12's case was dated 10/28/09. Under a summary of resident's status/needs, the following were listed: "activities of daily living, gastrostomy feeding, pain management, comfort care measures, wound care, behavior monitoring... resident/family concerns: none at this time." The interdisciplinary team plan of care for social	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 13	F 250		

service interventions listed the following: "Patient is on comfort care;" "Visitors: father calls but lives out of state;" "Patient is on comfort care, appears to be socially isolating;" "Hospice referral made, but not picked up due to no payer source."

An interview with the Social Worker (Employee #17) assigned to the case revealed the other contracted hospice agency also declined, but acknowledged this was not documented. Review of the social service documentation also revealed that Resident #12 could not participate in a phone conversation on 10/26/09, with the social security office because Resident #12 would not wake up, possibly related to recent pain medication. A second attempt on 10/27/09, was also unsuccessful.

Employee #17 acknowledged that the physician had spoken to Resident #12 regarding her end of life, possibly decreasing the tube feeding, increasing pain management or other interventions to provide comfort care, but Resident #12 did not want to do this. Documentation only described, "Doctor in facility continues to attempt to talk with patient regarding hospice/comfort care measures without success."

Employee #17 confirmed that the facility, specifically social services, have not addressed what Resident #12's choices were regarding funeral services, or have provided possible spiritual support, since Hospice had declined, because "that was not something we normally do."

Resident #15

Resident #15 has been a resident of the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 14	F 250		

since 7/23/09. Interviews with Resident #15 on 11/4-5/09 revealed that Resident #15 was planning to leave the facility on 12/1/09, to move into a handicapped apartment. Resident #15 indicated that he had to make all the arrangements himself, without the assistance of social services.

Review of the last care conference dated 7/29/09, revealed the following notes: "Patient is pending ASI housing and continues to work towards discharge. Patient continues to plan for discharge and social service to continue assisting as needed." There was no evidence in the clinical record that social services had been assisting the resident on a regular basis to prepare for discharge, except that on 10/2/09, the entry noted that "per patient's request, to coordinate waiver services with upcoming discharge once Accessible Space Inc. approves the patient for housing." There was no further documentation referencing whether or not the resident had been approved, or how social service was assisting the resident in this process.

Resident #16

Resident #16 was admitted to the facility on 10/15/09, for antibiotic therapy via a percutaneous intravenous central catheter (PICC). The resident's primary diagnosis was infection of a hip joint revision.

An interview on 10/6/09, revealed that Resident #16 was the primary income source for his family. At the present time, the family was relying on community support including family shelter services and food. Resident #16 expressed concern that he could not look for work while in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 15	F 250		

the facility, and that his family was lacking basic needs because of this. He acknowledged he had not been given any discharge plans except for being required to stay at the facility for six more weeks for the antibiotic therapy. Resident #16 expressed concern that if his wife's asthma and respiratory infection became worse, she would require hospitalization, leaving their ten year old son without any adult at the shelter, and that this could result in the child being placed in foster care. Resident #16 expressed a concern that if he signed out against medical advice to take care of his son, he would lose his health benefits.

Resident #16 also expressed a desire to go out on pass, but was told that any resident with a PICC line could not go out on pass because of a risk for illegal drug use. Resident #16 wanted to go out on pass so that he could reassure himself that his family was safe at the shelter. Resident #16 also indicated that the family shelter was above a community health clinic.

Review of the facility policy regarding pass privileges revealed only that if a resident had a history of substance abuse, and had a PICC line, pass privileges would not be considered. Review of Resident #16's medical history revealed no prior drug use.

Review of his care plan revealed there was no discharge planning care plan or interventions identified to assist Resident #16 in managing his own medical needs to facilitate a earlier discharge.

An interview with the Social Worker (Employee #10) assigned to Resident #16 was conducted on 11/6/09. Employee #10 denied any knowledge of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 16	F 250		

Resident #16's concerns. However, she acknowledged there had been no research into the possibility of Resident #16 being able to be discharged either to home health or some other community service to continue home antibiotic therapy. Employee #10 acknowledged that the pharmacy had not been contacted to evaluate whether they would deliver the antibiotic to the shelter, or to the clinic or other more secure location for home antibiotic use. Employee #10 acknowledged she had not inquired about home health or even contacted the physician regarding any of these possibilities. Employee #10 agreed she had not made a home visit to evaluate whether the environment at the shelter was clean or safe.

Employee #10 acknowledged she thought it was facility policy that any resident with a PICC line could not go out on pass.
Surveyor: 27206

Resident #9

Resident #9 was originally admitted to the facility on 5/1/09, with readmission on 8/24/09. The resident's diagnoses included lung and prostate cancer, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and hypothyroidism.

The minimum data set (MDS) dated 5/6/09, indicated the resident's cognitive skills for decision-making were not impaired, and that he "usually understands others, but hears in special situations only."

Review of Resident #9's record revealed that a Social Services Intake was conducted on 8/27/09,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 17 and included the note: Hearing aids do not provide relief, has had 3 sets and "They don't work." A Social Services Case Note, written on 9/9/09 by one of the facility's Social Workers, Employee #17, indicated that Resident #9's power of attorney (POA) requested that the resident see a dentist and audiologist. There were no subsequent Social Services notes in the record. On 11/6/09 at 7:45 AM, Resident #9 was interviewed about his hearing aids. The resident responded, "I sent them back because they didn't work. I don't have the money now." When interviewed if he would like to try new hearing aids if money was not a factor, the resident said, "I'd like to try." The resident also shared that he preferred eating in his room, because communication was difficult in the dining room. The Social Worker, Employee #17 was interviewed on 11/6/09 at 8:30 AM. The employee confirmed that an audiologist appointment was not made for the resident, and that the resident was not using hearing aids. The employee indicated that she asked Resident #9 in early September about getting new hearing aids, and that the resident refused. When interviewed if she asked the resident about using hearing aids since then, the employee relayed that the resident did not bring up the issue to her and that she had not asked him about it.	F 250		
F 279 SS=F	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 18 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 22116 Based on policy review interview, and record review, the facility failed to ensure comprehensive care plans were reviewed and revised to reflect the resident's comprehensive plan of care for 6 of 24 residents (Resident #13, #15, #16, #1, #6,# 21). Findings include: Review of the facility's Interdisciplinary Care Planning policy, effective 5/17/2001, described the comprehensive care plan as follows: "Care plans are revised as changes in the resident's condition dictates; care plan reviews occur during the twice-weekly interdisciplinary team sessions." An interview with the Minimum Data Set (MDS)	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19	F 279		

staff, Employees #23 and #24, on 11/4/09 and 11/9/09, confirmed that comprehensive care plans were not taken to the care conference meetings for review for appropriateness. It was also determined that care conference meetings could be held prior to the completion of the MDS assessments, which could identify specific declines or needs of residents. An interview with Employee #25 on 11/4/09, revealed that the MDS department was only responsible for the care plans as related to the MDS, not other needs. Employee #25 indicated that updating other aspects of the care plans was the responsibility of the other disciplines.

Review of the comprehensive care plans revealed these care plans were not kept up-to-date, nor did they identify specific needs of residents.

Resident #13

Resident #13 was admitted to the facility on 8/17/09. Review of the clinical record revealed the resident may have been a victim of Elder Abuse by a significant other. The resident's family requested that the alleged perpetrator not be allowed access to Resident #13 or to information about her care/condition. A care plan had not been developed to ensure that appropriate measures were in place to protect the resident.

The record also revealed a care plan for an indwelling catheter. Physician orders revealed the catheter had been discontinued 11/2/09. There was no evidence the care plan had been updated, or that Resident #13 was now on a bladder training program.

Resident #15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 20	F 279		

Resident #15 was admitted to the facility on 7/23/08, with the primary diagnoses of acute respiratory failure, sleep apnea and morbid obesity. When Resident #15 was admitted to the facility, he had a tracheostomy. An interview/observation with Resident #15 revealed his tracheostomy was well healed. He now used nasal cannulas for oxygen therapy.

Review of Resident #15's care plan revealed that a care plan dated 7/24/08 had goal dates changed every three months; however, this care plan still indicated the following identified problem: "Requires oxygen therapy related to respiratory failure with tracheostomy tube: Shiley #8." The interventions listed were to administer oxygen at 1-2 liters/minute vial tracheostomy mask, and suction as needed. A request for a respiratory consult was also indicated, but there was no date as to when this was accomplished.

Resident #15 was also care planned for being bedfast. The resident was observed to ambulate in a wheel chair, although he confirmed he could not transfer by himself.

Resident #15 was a diabetic and his care plan, dated 7/24/08, indicated he required a dietary consult. There was no evidence this consult had been completed.

Resident #15 was planning to be discharged on 12/1/09, but there was no evidence in the record of any discharge planning.

Resident #16

Resident #16 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21	F 279		

10/15/09, for antibiotic therapy via a percutaneous intravenous central catheter (PICC). His primary diagnosis was infection of a hip joint revision. An interview on 10/6/09, revealed that Resident #16 was the primary income source for his family. At the present time, the family was relying on community support for shelter and food. Resident #16 expressed concern that he could not look for work while in the facility, and that his family was lacking basic needs because of this. He acknowledged he had not been given any discharge plans except for being required to stay at the facility for six more weeks for the antibiotic therapy.

Review of the resident's record failed to reveal a discharge plan or interventions identified to assist Resident #16 in managing his own medical needs to facilitate an earlier discharge.
Surveyor: 19948

Resident #1

Resident #1 was originally admitted to the facility on 5/5/09, with an re-admission date of 7/24/09. Her diagnoses included End Stage Renal Disease requiring dialysis treatment three times per week, diabetes (not controlled) and morbid obesity. She was presently in contact isolation for Clostridium difficile (C-diff).

The resident had a care plan for fall risk potential. The care plan problem, goal and approaches were preprinted and used for all residents with the potential for falls. The approaches, use of treaded slipper socks, bedside mats, bed, wheelchair alarms in place, bedrails on side of bathroom in down position, and bedside commode on room, were part of Resident #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 22	F 279		

care plan for at risk for falls. Resident #1 was bedbound with extremely limited use of her extremities. The care plan had not been developed for her specific needs.

Resident #6

Resident #6 was admitted to the facility on 10/20/09, with diagnoses that included aortocoronary bypass, atherosclerosis, hypertension and depression. Her admission was for a short term stay to recover from her heart surgery.

The resident was receiving an anti-coagulant every evening. There was no evidence of a care plan that specified approaches in the care of residents receiving anticoagulant therapy.

Resident #21

The resident was admitted to the facility with the diagnoses of debility, late effects of a cerebral vascular accident, dementia and hypertension.

A care plan for impaired decision making was developed on 7/01/09, with a goal date of 9/23/09. There was no evidence that the care plan had been reviewed or revised to reflect Resident #21 current status.

A care plan for impaired hearing was developed on 7/01/09 with a goal date of 9/23/09. There was no evidence that the care plan had been reviewed or revised to indicate that the original approaches to the problem were effective and remained appropriate.

A care plan for assist with the Activities of Daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 23 Living (ADLs) was developed on 7/01/09, with a goal date of 9/23/09. There was no evidence that the care plan had been reviewed or revised to reflect if the approaches remained pertinent in the care of Resident #21. A care plan for bladder and bowel incontinency was developed on 7/01/09, with a goal date of 9/23/09. There was no evidence that the care plan had been reviewed or revised to reflect Resident #21 current status. A care plan for risk of dehydration was developed on 7/01/09 with a goal date of 9/23/09. There was no evidence that the care plan had been reviewed or revised to indicate if Resident #21 was still at risk for dehydration.. Present were also care plans for skin breakdown, risk for falls, seizure medication use, urinary tract infections and abrasions. All of the care plans had been initiated on 7/01/09, with goals dates of 9/23/09. There was no evidence that any of the care plans had been reviewed or revised to reflect the current status or needs of Resident #21.	F 279		
F 286 SS=B	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Surveyor: 27206 Based on record review and interview, the facility failed to maintain resident assessment data in active clinical records for 3 of 24 residents (Resident #8, #9, #23).	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 24 Findings include: A review of 24 resident records during the survey period revealed that three (Residents #8, #9, and #23) of the records did not contain Resident Assessment Protocol (RAP) summary forms. The RAPs for the three residents were also not available in the medical records department. One of the facility's clinical documentation specialists, Employee #23, was asked about the location of the RAPs, and he retrieved the assessments from his computer. The employee acknowledged that all RAP summary forms completed within the previous 15 months should be readily accessible to all who need to review the information.	F 286		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Surveyor: 22116 Based on record review and interview, the facility failed to ensure accurate documentation of Restorative (RA) programs ordered for 1 of 24 residents (Resident #15). Findings include: Resident #15 was admitted to the facility on 7/23/08, following an acute-care hospitalization of	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 25 respiratory failure and morbid obesity. Review of the clinical record revealed that Resident #15 had received intermittent periods of physical therapy. The record revealed that when Resident #15 had leveled out with his abilities for therapy, he was placed in the RA program to maintain his level of achievement. Review of the clinical record revealed Resident #15 required surgery on both of his feet on 10/7/09. This prevented him from participating in some of the RA programs, so these programs were allegedly placed on hold (see below). The clinical record RA sheets for October and November had no documentation these programs were on hold. The specific dates from 10/8-17/09 had the RA aide's initial and circled, to indicate care had not been provided. On the back of these sheets, the RA aide wrote the program was on hold. From 10/18-28/09, and from 11/1-9/09, there was no documentation on either side of the RA sheets to indicate whether the program had been performed or was still on hold. An interview with the RA aide responsible for Resident #15, and with the supervisor of Rehabilitation Services on 11/9/09, revealed that once a resident was placed on an RA program, the program was to be monitored by nursing. This interview also revealed that unlike the medication and treatment records which indicate a change or hold of a medication or treatment, the RA sheets were not changed to reflect these changes.	F 318		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 26	F 325		

assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Surveyor: 19948
Based on record review, staff interview, and policy review, the facility failed to ensure that 1 of 24 residents maintained acceptable parameters of body weight, and failed to notify the appropriate staff that weight loss had occurred (Resident #20).

Findings include:

Resident #20 was admitted to the facility 3/18/03, with diagnoses including a below the knee amputation (BKA), schizophrenia, depression, anxiety and psychosis.

Review of the weight document for 9/21/09 for Resident #20 indicated that his weight on the wheelchair scale was 181 lbs. His weight on 10/18/09 on the stand up scale was 169.60 lbs. There was no documentation that the resident was re-weighed to validate the 11.4 lb weight loss, or that the physician or dietary was notified.

A care plan, dated 5/27/09, identified Resident #20 at being at nutritional risk due to chewing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 27 difficulties with mechanically altered diet, left BKA, and depression. One of the approaches was to monitor and record his monthly weights. Review of the Skilled Nursing Policy, entitled "Resident Weight System," with an effective date of 06/06/07, revealed that the team was to immediately re-weigh any resident weighing more than 99 lbs if there was a loss of five pounds or more, and that the re-weigh figure was to be recorded on the Weight Report form. That information was then to be entered into a computer system. The Interdisciplinary Team was to review the data on the weight quality rounds, and the appropriate information would be distributed to the dietitians, nursing staff, Social Services, and Activities. In an interview with Employee #3 on 11/9/09, she agreed that this policy was not followed.	F 325		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 28 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Surveyor: 26252 Based on record review and staff interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 3 of 25 residents (Resident #5, #11, #13). Findings include: Resident #5 Resident #5 was admitted to the facility on 8/4/2009, with diagnoses including late effects of cerebrovascular disease, facial weakness, other persistent mental disorders, senile dementia, and debility. Medication orders included psychotropic medications Geodon 20 milligrams (mg) twice a day for agitation, yelling, and pulling at others, and Risperdal 0.5 mg twice a day for behaviors, yelling, and hallucinations. On 11/3/09, Resident #5's medical records were reviewed. Review of Resident #5's "Pharmacist Progress Note/Medication Regimen Review" record revealed that in an addendum entry dated 9/11/09, the facility's consultant pharmacist, Employee #18, recommended discontinuing	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 29	F 329		

Geodon and continuing to monitor behaviors with Risperdal alone. The entry indicated the pharmacist had reviewed both the Geodon and Risperdal and that nursing had reported that Resident #5 was "out of it/snowed," and likely due to the medications.

Review of Resident #5's "Medication Administration Records (MAR)" and "Physician's Orders" indicated that the resident continued to receive Geodon, and that the medication had not been discontinued. The MAR for October 2009, indicated that both the Geodon and Risperdal were held/not given on the 13th, 19th, 22nd, 23rd, 25th and 28th. A single entry on 10/19/09 indicated all eight AM medications were not given due to the resident being "very sleepy". There were no other notations as to why Geodon or Risperdal were held on the other days that it had not been given. The MAR for November 2009, indicated that on 11/3/09, both Geodon and Risperdal had not been given. There was no explanation as to why the medications were held.

On 11/5/09, an interview with the Medication Nurse, Employee #26, indicated she had held and not given Resident #5's Geodon and Risperdal on 11/3/09, because the resident was "sleepy." The nurse indicated she had not seen the recommendations made by the pharmacist in September, and that it was not routine for her to review the pharmacist's notes. The nurse further indicated she was not familiar with the facility's process for notifying the physician of the pharmacist recommendations.

On 11/5/09, in separate interviews with the Director of Nursing, Employee #11 and the facility's Geriatric Clinical Documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 30	F 329		

Specialist, Employee #24, indicated there was not a clear process on how pharmacist recommendations were reviewed and communicated to the physician.

A review of the facility's Psychotropic Committee meeting minutes for August 2009, September 2009 and October 2009, revealed a single notation for Resident #5 in the September 16, 2009 minutes. The entry in the September minutes for the resident read, "Not active any more, need to check on her." The September meeting was attended by several staff including the facility's consultant pharmacist, Employee #18, the Geriatric Clinical Documentation Specialist, Employee #24 and Administrative Secretary, Employee #27. Neither Employee #24 or #27, were able to explain or expound on what was to be done for Resident #5, or who was assigned to do the follow-up as a result of the September meeting.
Surveyor: 22116

Resident #13

Resident #13 was admitted to the facility on 8/17/09, with the primary diagnoses which included rehabilitation following a fractured hip, and Herpes Zoster with systemic involvement.

On admission, Resident #13 was prescribed a Lidocaine patch to be applied transdermal on both her neck and her knee daily. These patches were 700 milligram strength.

An interview with the Medication Nurse revealed Resident #13 refused both patches to be applied. Instead, the Medication Nurses were cutting one patch and "applying a strip on the neck and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 31	F 329		

rest the patch on the knee". The medication nurse confirmed the strip was approximately one to one and a half inches long and the width of the patch. The Medication Nurse also confirmed this practice had been going on for some time, but the physician had not been informed of it as of 11/4/09.
Surveyor: 27206

Resident #11

Resident #11 was originally admitted to the facility on 3/27/08, with readmission on 6/16/09. The resident's diagnoses included cerebrovascular accident, chronic obstructive pulmonary disease, diabetes, renal disease, hypertension, and hypothyroidism.

Medication orders included Cytomel 50 mcg once a day for thyroid hormone replacement.

Review of Resident #11's record revealed that on 10/9/09, the facility's consultant pharmacist, Employee #18, wrote a recommendation to decrease Cytomel to 25 mcg, because "a TSH (thyroid stimulating hormone) on 8/21 was at 0.13 showing oversuppression."

At the time of the survey, on 11/6/09, there was no evidence that the Resident #11's physician received this recommendation from the pharmacist. Both the resident's November Medical Administration Record (MAR) and physician progress notes dated 10/23/09, indicated that the resident was still receiving Cytomel 50 mcg.

In an interview with the Charge Nurse, Employee #15, on 11/6/09 at 11:00 AM, the nurse explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 32 that the protocol regarding pharmacy communication involved sending a pharmacy communication form to the resident's physician, and the physician documenting on the form whether or not the recommendation was agreed to. This form was then put into the resident's record, and nursing staff used it to update the MAR. Employee #15 reported that she did not see a communication form pertaining to Cytomel in Resident #11's chart.	F 329		
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 33 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Surveyor: 19948 Based on observation, the facility did not have posted current information as to the resident census and the actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants responsible for resident care per shift. Findings include: Upon entry to the facility on 11/03/09, noted in the lobby was the posted information of the facility name, the resident census and the number of registered nurses, licensed practical nurses and certified nursing assistants responsible for patient and the number of hours worked, by shift. However, the most current information was dated 10/28/09. The posted information was not updated until 11/4/09.	F 356		
F 371 SS=D	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 34 by: Surveyor: 27206 Based on observation, policy review, and interview, the facility failed to ensure food was stored under sanitary conditions. Findings include: A tour of the facility's kitchen on 11/3/09 at 8:00 AM revealed the following: 1. There was an inadequate amount of sanitizer in the wiping cloth buckets. 2. The floor of the walk-in freezer had debris and was in need of cleaning. 3. In the dry storage room, a scoop was being stored inside the flour bin. 4. There were no paper towels at the handwashing sink. 5. In the refrigerator, pre-poured cups of milk were covered and had a date of 10/30. The Food and Nutrition Services Manager, Employee #14, indicated that the kitchen's policy was to discard prepared foods after two days. There was no written policy addressing the timeframe for discarding food.	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 35 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 26252 Based on observation and staff interview, the facility failed to ensure safe and proper storing of drugs and biologicals, and the disposal of outdated medications. Findings include: On the morning of 11/9/09, an observation of the facility's medication room was made. The following was found: 1) The medication refrigerator was at 28 degrees Fahrenheit (F); the temperature log was not	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 36 completed for 11/5/09 and 11/9/09; the temperatures on the log ranged from 30-34 degrees F; there were several prescription medications in the refrigerator with labels indicating "do not freeze." 2) Expired medications in the refrigerator included two containers of Barium Sulfate suspension with the expiration date of 06-2009, and a box of Acetaminophen Suppositories 650 milligrams (mg), with the expiration date of 8/09. 3) One bottle of house stock Vitamin B12 that had been opened, was undated and returned to house stock shelves. 4) One package of house stock Halls Cough Drops that had been opened, was undated and returned to house stock shelves. 5) There were external products stored next to internal products, which included Sarna Lotion, Calmoseptine Ointment 6) One sterile BBL Culture Swab EZII with the expiration date of 5/2009. 7) In an unlocked and unidentified cupboard there were two separate bags of multiple bottles of prescription medications. Immediately following the medication room observations, Licensed Practical Nurse (Employee #28) and Registered Nurse (Employee #21) were interviewed. Both nurses acknowledged the medication room findings and confirmed that the bags of multiple bottles of prescriptions were medications that had been brought in from home at the time of two individual residents' admissions. The nurses indicated the two bags of prescription medications were to be returned to the residents when discharged and acknowledged the medications should have been stored and identified accordingly.	F 431		
F 441	483.65(a) INFECTION CONTROL	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 SS=F	Continued From page 37	F 441		

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Surveyor: 22116

Based on observations, interviews, and record review, the facility failed to: 1) establish and maintain an infection control policy to provide a safe, sanitary and comfortable environment; 2) establish a comprehensive infectious disease monitoring tool; 3) ensure staff consistently followed infection control precautions; and 4) educate residents/visitors regarding specific infection control precautions.

Findings include:

Of the facility's approximately 75 semi-private resident rooms, 24 were identified as isolation rooms. Deficient practices are described below:

1) Signs indicating specific isolation precautions were inconsistent, as evidenced by:
One set of contact isolation signs indicated that personnel protective equipment (PPE) of gowns and gloves were to be used whenever the room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38	F 441		

was entered. Another set of contact isolation signs indicated personnel were only to wear PPE when direct contact care of residents were being performed.

2) Residents with respiratory infections were placed in the same room as residents with wound infections. The interim Infection Control Nurse (ICN) indicated this occurred only if the infecting organism was the same. However, Isolation signs were only placed at what was considered the "higher risk " infection. The respiratory isolation signs indicated the only PPE to be worn was a mask.

3) A random observation revealed the presence of a family member visiting a resident who was in respiratory isolation. The family member did not have a mask covering her nose and mouth. A registered nurse administered medications to the resident and did not instruct the family member of the need to properly position the face mask.

4) A registered nurse came out of a room identified as contact isolation after removing her PPE (gown and gloves). She then went back into the room, without any PPE, to wash her hands at the resident sink, leaning over the resident who was at the sink.

5) A housekeeper carried a bag of trash out of a room identified as contact isolation. The housekeeper was wearing gloves, but no other PPE. She was wearing a long sleeve sweat-shirt hoodie jacket. The housekeeper pushed the bag of trash into a trash receptacle up to her elbows, contacting the sides of the receptacle with her jacket. Without removing her gloves, the housekeeper then removed a clean PPE gown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 39	F 441		

from the isolation cart. The housekeeper acknowledged she was aware she should have been wearing a PPE gown while she removed trash from the resident's room, and that she should have removed her gloves and washed her hands before accessing the clean isolation cart supplies. Her reply was that she was in a hurry.

6) Random observations of staff and residents during the survey period revealed one resident who when accompanied by a staff member, wore a mask for respiratory isolation, but when unaccompanied, was observed throughout the facility without a respiratory mask.

7) Review of residents' care plans revealed no care plan for infection control; specifically what isolation a resident required, how the resident, family would be educated to ensure compliance, and/or what would be done to minimize the required isolation. There was also no indication as to how the resident could participate or be accommodated for activities within the limits of the required isolation.

8) Random observations of isolation carts revealed that one cart had no gloves and several carts had no disinfecting wipes.

9) Trash cans were not located at the door of the resident's rooms, requiring staff to remove their PPE while still within the resident's room, sometimes a distance of 10 feet. Trash cans were also observed to be overflowing with discarded masks, gloves, or disposable gowns, and falling onto the floor.

10) An interview with a resident in contact isolation revealed he had not been instructed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 40	F 441		

what contact isolation meant. He confirmed he had wounds on his leg, participated in activities, and traveled throughout the facility. Review of clinical records revealed no evidence that residents or their families were regularly instructed on the required isolation.

11) Interviews with the Administrator, Director of Nursing (DON), and interim Infection Control Nurse revealed that both the DON and the ICN were new to their positions at the facility, and that the previous ICN did tracking of infections. The only infection that previous nurse tracked was urinary tract infections for 2009, and this tracking ended in May.

12) An interview with the interim Infection Control Nurse confirmed that the facility had no process to remove residents from isolation.

13) A review of the tuberculosis (TB) screening performed on current residents revealed that 52 residents were not current for 2009.
Surveyor: 19948

14) Employee #5 transferred from another position within the the same corporation. Her employee file indicated that a PPD for tuberculosis had been completed on 12/04/07 while in a previous position. In her current position in the skilled nursing facility, her most recent PPD for tuberculosis had not been completed until 6/08/09.

The Corporation Health Network Policy titled, "Employee Screening," with an effective date of 10/01/06, stated that "Tuberculosis testing will be completed at the time of employment and done annually thereafter with results in the employee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 41 file." 15) Resident #19 was admitted to the facility on 7/01/09, with diagnoses that included dementia, Parkinson's Disease and diabetes. He was transferred out of the facility for behaviors and did not return. Review of the closed record (the Medication Administration Record and the TB Screening and Vaccination Record) revealed that Resident #19 was administered a 1st step PPD skin test for tuberculosis on 7/02/09 which was never read. There was no evidence that a 2nd step skin test was ever administered. 16) Resident #20 was admitted to the facility 3/18/03. His diagnoses included a right below the knee amputation, schizophrenia, depression, anxiety and psychosis. Review of Resident #20's record showed no evidence of a PPD skin test for tuberculosis having been administered since 6/19/08. There was no documentation that the 6/19/08 skin test had been read. The Health Network Policy for the facility entitled, "Tuberculosis Testing", with an effective date of 10/01/06 stated that, "A one-step PPD is done annually thereafter." Surveyor: 27206 17) During a tour of the facility on 11/3/09 at 9:00 AM, an opened carton of Med Pass 2.0 high calorie/protein supplement was observed on a med cart on F hall. Someone had written "4 AM" on the top of the carton, and the nurse on duty, Employee #19, confirmed that 4:00 AM was when the supplement was opened. The temperature of the supplement was 72.2 degrees Fahrenheit (F).	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

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F 441	Continued From page 42 According to the instructions on the carton, the supplement was to be refrigerated after opening. One of the ingredients listed was "milk protein isolate," and the product needed to be kept at a temperature below 41 degrees F. Another opened carton of Med Pass 2.0 supplement was observed on D hall at 1:25 PM, with an open time of "8 AM." The temperature of this supplement was 72.3 degrees F. 18) On 11/4/09 at 8:00 AM, an ice scoop was observed laying directly on ice in an ice chest on D hall, rather than in a scoop holder.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Surveyor: 22116 Based on observation and interview, the facility failed to ensure that all toilet facilities used by residents were equipped with call-light systems that communicated with the nursing stations. Findings include: A random observation at 10:45 AM on 11/10/09, revealed an resident in a wheelchair approached the main information desk and asked the staff member (Employee #20) for the key to the visitors' bathroom. Employee #20 gave the individual the key. This restroom was located in the main entrance hall. There was no call light equipment or emergency alerts within the	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295034	A. BUILDING _____ B. WING _____	11/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN SKILLED NURSING	1835 ODDIE BLVD SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 43 restroom, and the door was self-locking when closed. Upon interview, Employee #20 confirmed this resident used the visitors' restroom on a frequent basis. Employee #20 confirmed she was aware there was no call light system located in this restroom, and she indicated that if the resident needed assistance, "the resident would bang on the metal trash can if she needed help." Employee #20 confirmed she had access to another key to open the restroom door. Employee #20 also related that this particular resident had a history of seizures. An interview with the Administrator and the Maintenance Manager at 10:50 AM on 11/9/09, revealed that this restroom was to only be used by visitors, because there was no call system in place for residents to signal for assistance. They also confirmed that after hours this key was still accessible at the information desk, when no staff member could monitor its use.	F 463		